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INDIAN INSTITUTE OF PUBLIC ADMINISTRATION

Centre for Training & Research in
Municipal Administration
New Delhi

Project on Integrated Services for
Children and Youth in Urban Areas

Experts' Meeting on 'Family and
Child Health Centre' to be held
on 3-4 December, 1971

PROVISIONAL PROGRAMME

- Friday, 3rd December, 1971

INAUGURAL Session	10.00 a.m. to 10.45 a.m.
Coffee Break	10.45 a.m. to 11.00 a.m.
First Session	11.00 a.m. to 1.00 p.m.
Lunch Break	1.00 p.m. to 2.30 p.m.
Second Session	2.30 p.m. to 4.00 p.m.
Tea Break	4.00 p.m. to 4.15 p.m.
Session continues	4.15 p.m. to 5.30 p.m.

- Saturday, 4th December, 1971

Third Session	10.00 a.m. to 11.15 a.m.
Coffee Break	11.15 a.m. to 11.30 a.m.
Session continues	11.30 a.m. to 1.00 p.m.
Lunch Break	1.00 p.m. to 2.30 p.m.
Fourth Session	2.30 p.m. to 4.30 p.m.
Tea	4.30 p.m. to 5.00 p.m.

INDIAN INSTITUTE OF PUBLIC ADMINISTRATION

(Centre for Training & Research in Municipal Administration)
Indraprastha Estate, New Delhi-1.

Project on Integrated Services for Children and Youth in Urban Areas

Consultancy Meeting on 'Urban Family and Child Health Centre'
(3-4 December, 1971)

Programme

Friday, 3rd December, 1971

10.00 a.m. to 10.45 a.m. — Inaugural Session

Chairman: — Dr. J.B. Srivastav, Director-General of Health Services, Government of India.

Welcome Address: — Prof. G. Mukharji, Director, IIPA, New Delhi.

Inaugural Address: — Shri P.P.I. Vaidyanathan, Additional Secretary, Department of Soci-l Welfare, Government of India.

Chairman's Address: — Dr. J.B. Srivastav Director-General of Health Services, Government of India.

Vote of Thanks.

10.45 a.m. to 11.00 a.m. — Coffee break

11.00 a.m. to 01.00 p.m. — First Session

i) Review of existing services and their organizational set-up, in Urban Areas.

ii) Scope of activities and services to be provided at Urban Family and Child Health Centre and population coverage

Lunch break.

2.30 p.m. to 5.30 p.m. — Second Session

iii) Staffing patterns

iv) Equipment and budgetary needs

-continued

Saturday, 4th December, 1971

10.00 a.m. to 01.00 p.m. Third Session

v) Financial arrangements

vi) Organisation and administration

Lunch break.

2.30 p.m. to 4.30 p.m. Fourth Session

vii) Orientation of project staff and other personnel.

viii) Review of discussion.

List of Participants

1. Dr. J.H. Bhatia
   Associate Professor of Community Health,
   All India Institute of Medical Sciences
   Ansari Nagar, New Delhi-16

2. Dr. J. Biswas
   H.C. Mukherjee Memorial Health School
   P.O. Singur (Dist. Hooghli)
   West Bengal

3. Dr. D.N. Chaudhri
   Dy. Secretary
   Government of India
   Ministry of Health and Family Planning
   Department of Family Planning
   Nirman Bhavan
   New Delhi-11

4. Dr. A.S. Chikeramane
   Head of Department of Paediatrics and Nutrition
   Medical College
   Baroda (Gujarat)

5. Dr. S.P. Dabba
   Professor of Social and Preventive Medicine
   Lady Harding Medical College and Hospital
   New Delhi-1

6. Dr. N.S. Deodhar
   Head, Department of Social and Preventive Medicine
   B.J. Medical College
   Poona-1

7. Dr.(Mrs.) H. Dhillion
   Deputy Director (MCH)
   Health Department
   Punjab Government
   CHANDIGARH

8. Sister Sara Kaithathera
   Holy Family Hospital
   Okhla Road
   New Delhi-25

9. Dr. Lakshmi Kant
   Additional Director of Medical Health Services
   Government of Bihar
   Patna

10. Dr. Ko Ko, Regional Advisor in
    Community Health Services, World Health Organisation
    Indraprastha Estate, New Delhi-1

11. Shri D.N. Madhok
Joint Secretary
Government of India
Ministry of Health andFamily Planning
(Dept. of Family Planning)
Nirman Bhavan
New Delhi-11

12. Dr. (Mrs.) Prabha Malhotra
Associate Professor of MCH and Family Planning
National Institute of Health Administration and Education
B-55, Greater Kailash
New Delhi-48

13. Dr. S.V. Mapuskar
Medical Officer-in-charge
Primary Health Centre
Dehu, Dist. Poona
Maharashtra

14. Dr. S. Nagaraj
Professor of Health and Extension Education
National Institute of Health Administration and Education
E-16, Greater Kailash
New Delhi-48

15. Shri Meher C. Nanavatty
Advisor
Department of Social Welfare
Government of India
Shastri Bhavan
New Delhi-1

16. Dr. P.V. Parulekar
Executive Health Officer
Public Health Department
Municipal Corporation of Greater Bombay
Mahapalika Marg
Bombay-1

17. Dr.(Miss) S. Phadke
UNICEF
South Central Asia Regional Office
11, Jor Bagh
New Delhi-3

18. Dr. B.G. Prasad
Professor, Social and Preventive Medicines
Medical College
Lucknow (U.P.)

19. Dr. V. Ramakrishna
Regional Adviser in Health Education
World Health Organisation
Indraprastha Estate, Ring Road
New Delhi-1

20. Prof. S.N. Ranade
Principal
Delhi School of Social Work, University Marg
Delhi

21. Dr. I. Bhooshana Rao
Dy. Commissioner of Family Planning
Ministry of Health and Family Planning
Nirman Bhavan
New Delhi-11

22. Dr. B.S. Sehgal
Director, Central Health Education Bureau
Temple Lane, Kotla Road
New Delhi-1

23. Dr.(Mrs.) Muktha Sen
Director
Indian Institute of Social Welfare and Business Management
College Square West
Calcutta-7

24. Dr J.B. Srivastava
Director-General of Health Services
Directorate of Health Services
Nirman Bhavan
New Delhi-11

25. Col. O.P. Varma
All India Institute of Hygiene and Public Health
Chittaranjan Avenue
Calcutta-12

INDIAN INSTITUTE OF PUBLIC ADMINISTRATION

1. Prof. G. Mukharji - Director
2. Shri Deva Raj - Director (CMA)
3. Shri V.M. Kulkarni - Project Specialist
4. Shri I.R. Khurana - Project Specialist

P - T.17.

5. Shri P.L.Trakroo	- Research Analyst
6. Shri R.K.Vishwakarma	- Research Analyst
7. Shri K.S.L.N. Sarma	- Statistician
8. Miss Shanta Kohli	- Jr. Research Analyst

Representative from City Survey Research Units

1. Dr. S.C. Jain	- Baroda
2. Shri M.S. Varma	- Lucknow
3. Miss M. Khandekar	- Bombay
4. Shri T.C.Tikkiwal	- Jaipur
5. Shri K.K. Singh	- Indore

Bustee

Community Health & Welfare Centre

for Mothers & Children

Dr. J. BISWAS

1 Centre for every 10,000 population with staff as follows:-

STAFF - P.H.N. .. 1 per 10,000 population

A.N.M.'s or Trained Dais*) 2 " " " . * only WBSF trained T.B.'s eligible

Balsevikas 2 " " "

Doctor (preferably DMCH with DPH) - 1 for 2 such centres i.e. 1 per 20,000 population.

1. Sweeper) per clinic G.D.A.'s to work alternatively as peon and darwan
2. G.D.A.

Function- Integrated Maternal and Child Health Care and Family Planning. This includes

(i) Health Education

(ii) Care of the mother during pregnancy, delivery (domiciliary midwifery where asked for) and the postnatal period of 1 yr. after deliveries.

(iii) Introduction of Family Planning as soon after delivery as possible and follow up.

(iv) Child Care from birth to 5 years.

(v) All Immunisations i.e. Tetanus Toxoid, vaccination for Smallpox, Triple Antigen (Diptheria, Tetanus and Whooping Cough), B.C.G. and Polio where available.

(vi) Nutrition Education and services i.e. talks, cooking and other demonstrations, distribution of milk, C.S.M. Bread etc. Special care for under or malnourished children and mothers.

(vii) Nursery School and Childrens play centre.

(viii) Mother Craft Classes.

(ix) Mothers recreation cum work centre.

Work Schedule

5½ day week i.e. 11 working sessions per week

	Sessions per weeks	
M.C.H. & F.P. Clinics	2	
Home visiting	4	
Records, Reports etc.	2	
Staff meeting (weekly in the beginning and monthly finally).	1	Special activity e.g. Health or Nut. Education Cinema Shows, cooking or other demonstrations. T.B. work may be arranged in these sessions once or twice a month.
Special Visit	1	
Mother craft and work activities	1	

Assistance for most of these activities are obtainable from following agencies in Calcutta.

1. Government Agencies

i) Health Education .. Mobile team from State Health Education Bureau.

ii) Nutrition Education .. Mobile team from Food Department

iii) Immunisations .. C.F.W.C. Calcutta, Dist. Tuberculosis Team and Calcutta Corporation (Vacc. & T.A.)

iv) Family Planning .. C.F.P.C. (Education and contraceptives).

2. Other Agencies

i) State Council for Child Welfare can be approached for assistance in running the Nursery School (Balwadi). They provide staff.

ii) Red Cross - can be approached for milk, food supplements, recreational facilities.

iii) Other Voluntary bodies, operating in the city can be approached to help with man power knowhow and materials if possible, in running the work and/or recreational centre. Also their assistance will be sought for profitable disposal of goods produced in the work centre.

BUDGET

Non-recurring

Furniture & Equipment		5,000

Recurring

Rent - At least 5 rooms,* (1 large) 3 lavatories, 2 Varandahas, 1 courtyard or lawn, Adequate water supply.	Rs.800/- p.m.	9,600
Salaries-** Dr. Rs. 300 x 12 (Rs. 300-20-500/-).		3,600
P.H.N. Rs. 300 x 12 (300-7-600/-)		3,600
*** A.N.M. Rs. 180 x 12 x 2 (Rs. 180-3-350/-)		4,320
Balsevikas - Rs. 100 x 12 x 2 (4 hours a day)		2,400
G.L.A. Rs. 100 x 12 x 3		3,600
Contingencies Rs. 100 x 12		1,200
Stationery, Cards etc. Rs. 100 x 12		1,200
Electricity Rs. 50 x 12		600
Repairs and renewals Rs. 50 x 12		600

* 1 room each for Doctor, Nurses, Balwadi (large), Medicines and Store.

** Draws salary from 2 centres.

*** T.D. Scale Rs. 150-1-230/-.

Medicines - (mainly food supplements e.g. Iron, Calcium, Multivits. Some ingredients for simple mixtures e.g. cough, carminative fever, antholmintics and sulfa drugs and ointments). Rs.200 x 12 2,400

&

Rs. 33,120

Objective - To fulfil as far as possible for this vulnerable group the requirements of Public Health which is 'the art and science of preventing disease, promoting health and prolonging life through organised community effort', and bringing about a state of complete physical, mental and social welbeing in the individual.

By giving such a service we reduce considerably the load on hospitals and bring health measures to such people as never go to hospital; the intention is also to prevent minor ailments from developing into serious ones. Those minor ailments that do not respond to simple treatment in 3 - 5 days are referred to hospital. All serious infections disease, are referred to hospital immediately.

4. Liason - must be maintained with

a) the nearest General Hospital for prompt attention to referred general patients, admission of complicated midwifery and/or gynaecology, sterilisation and sterility cases, laboratory and X Rays exams.

b) Infections diseases hospital.

c) Municipal or corporation health authorities for assistance in immunisations, disinfections, fumigations and ambulance service when and where necessary.

d) State Health Education Bureau.

e) State Nutrition Officer.

f) Food Department, Govt. of India and State for services of the Mobile Nutrition Education team.

g) District Tuberculosis Officer.

h) District Family Planning Officer.

i) State Council of Child Welfare.

j) Such voluntary bodies as are functioning in the district for Co-operation and assistance where necessary.

A special Referral Card system should be developed and utilised.

Leave Reserve - 1 set of staff should be maintained as leave reserve.

i.e.	F.H.N.	1	Rs. 300/-
	A.N.M.	1	Rs. 180/-
	Balsevika	1	Rs. 100/-
	G.D.A. (Peon or Darwan)	1	Rs. 100/-
	G.D.A. (Sweeper)	1	Rs. 100/-
			Rs. 780/- x 12
			= Rs.9,360/-

B. Administration

It is not advisable for the doctor-in-charge of the Centre to be burdened with the office work that such an establishment entails.

An administrative office should be set up centrally for each 6, 8 or 10 centres; with a senior Doctor-in-charge (since the services visualised have primarily a strong health bias).

Functions of this Office and the Administrator

1. Maintain liason and cordial relations with the different organisations mentioned above.

2. Arrange program of visiting teams according to the requirements of the centres under his charge.

3. Be responsible for all drawal and disbursal of funds and maintenance of all accounts.

4. Compile consolidate and maintain reports of the total work going on in the centres.

5. Visit each centre at least once a week to have first hand information of working and requirements of the centre. To advise and help in smoothing difficulties in the work where they arise. This will reduce a lot of paper work.

6. Sanction leaves and arrange for leave substitutes.

7. Arrange periodic meetings of staff at the office or individual centres for discussion of problems, exchange of ideas, presentation of reports preparation for special functions e.g. childrens day and arranging seminars with other bodies.

8. Arranging recreational facilities and gatherings for staff and groups of mothers and children sometimes separately and sometimes together.

9. Buy or otherwise provide all the requirements for the centres. Maintain a store from which requirements are issued regularly.

Facilities

1. Accommodation ... ... (with space for expansion)

Office	.. 3 rooms
Meeting room	- 1
Store	- 1
Garage	- 1
Lavatories	- 3
Verandahs	- 2
Lawns	- 1

2. Transport - For touring of Administrative Officer) .. 1 Jeep
For carrying supplies to centres

3. Staff

- Administrative Officer	...	1
- Head Clerk-cum-Accts.	...	1
- Cashier ..	...	1
- Store-Keeper ..	...	1
- Steno-Typist ..	...	1
- G.D.A. (Peon-cum-darwan) ..	...	3

- Sweeper	.. ..	1
Driver-cum-Mechanic	..	1

4. BUDGET

Non-recurring

Jeep	30,000
Furniture	5,000

Recurring

Administrator (Senior Doctor) Rs. 1,000 x 12 (Rs. 1,000-25-1200/-)	12,000
Head Clerk/Acctt. with requisite qualifications - Rs. 350 x 12 (Rs.300-10-600/-)	4,200
Cashier Rs. 300 x 12 (Rs.300-10-600/-)	3,600
Store-Keeper Rs. 250 x 12 (Rs.250-10-500/-)	3,600
Steno-Typist/Clerk Rs.250x12 (Rs. 250-10-500/-)	3,000
G.D.A. (Peon-cum-Durwan) Rs. 100 x 12 x 3 (Rs.100-1-120/-)	3,600
G.D.A. (Sweeper) Rs.100 x 12 (Rs.100-1-120)	1,200
Driver-cum-Mechanic Rs. 150 x 12 (Rs. 150-2-200/-)	1,800
Rent Rs. 1,000 x 12	12,000
Maintenance & repairs of Jeep Rs. 250x12	3,000
Stationery & Contingencies Rs. 200x 12	2,400
Telephone Rs. 50 x 12	600

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Proposed Staff	Population 40,000
Urban Health Centre	
by Dr. N.S. Deodhar	
1. Medical Officer I/C	One
2. Asst. Medical Officers (One would be L.H.C.)	Two
3. Public Health Nurse	One
4. Medical Social Worker	One
5. Health Educator	One
6. Staff Nurse	One
7. Health Inspectors	Two
8. Nurse Midwives	Two
9. Lab. Technician	One
10. Compounder/Pharmacist	One
11. Aux. Nurse Midwives (1 for 5000 population + 3 for H.Q.)	Eleven
12. Basic Health Workers (1 for 5000 population)	Eight
13. Balsevica	One
14. Drivers	Two

15. Office Staff

Sr. Clerk-cum-typist	One
Storekeeper-cum-Accountant	One
Statistical Assistant (Sr. Cl)	One
16. Ward boys	Three
17. Ward ayas	Three
18. Sweepers	Three
19. Lab. Attendent	One
20. Other Cl. IV. servants	Three
Total	Fifty one

This staff would provide all health services in an integrated manner and includes responsibilities for all National health programmes. (It is presumed that drainage maintained and refuse disposal will be looked after by special staff separately.)

From: Dr. N.S. Deodhar

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Project on Integrated Services for
Children and Youth in Urban Areas

Consultancy Meeting on "Family and Child Health Centre(Urban)"
(3-4 December, 1971)

A Note
on
The Activities and Organizational Pattern for the Urban Family and Child Health Centre

by

Dr. S. V. MAPUSKAR,
DEHU, DIST. POONA, MAHARASHTRA.

Activities and Organizational Pattern for Urban Family and Child Health Centre

by Dr. S.V. Mapuskar

A. INTEGRATED HEALTH SERVICES FOR URBAN AREAS

It is now accepted that integrating the health services, either in rural or in urban area, is advantageous in all respects viz. economically, professionally and for getting an optimum utilisation of the various types of services rendered for the promotion of health in the community.

As it stands today, this integration is tried and the integrated approach has been developed more extensively, in the rural areas through the agency of Primary Health Centres. In urban areas only a few projects have been undertaken on an experimental basis.

Urban area might have been neglected probably because it was presumed that urban areas have better medical and maternity facilities. However, with the accpetance of the concept of integration of health services a definite plan needs to be formulated. An organisational and working pattern will have to be decided upon for providing integrated health services in urban areas.

While doing this one can freely draw from the experience gained in the rural areas. It may be noted that excepting sophisticated urban areas and parts of big cities, the smaller towns and periphery of larger towns are essentially a queer superimposition of urbanisation on the rural surroundings.

B. SCOPE OF SERVICES TO BE RENDERED THROUGH THE F.C.H.C.

(1) Present multiplicity of services

At present the facilities for health that exist in urban areas are fragmented and are operated through several agencies. Besides, these facilities differ from place to place depending on the size of the municipality, the income of the municipality and the extent of involvement of the state health service within the municipal limits.

From the point of view of utilising existing facilities fully and adding up new dimensions to the health activities in urban area it would be necessary to bring all these facilities under one roof and agency (we may name it as F.C.H.C.). This agency could be given a specific population and area, details of which are discussed subsequently.

(2) Services to be rendered through FCHC

Further, if we want to decide the ways for integration of all these activities it would be necessary, in the first place, to decide on the services that we would like to render to the urban community through this agency, namely FCHC.

(3) Modus Operandi

(3a) Family as a unit

In the given area while rendering comprehensive health care it has been found to be more convenient to consider each family as a unit. This helps in considering the family problems and the health needs of the family in proper perspective taking into consideration the economic status as well as the social and cultural status of the family. In addition, the actual living conditions inside and outside home could be given due consideration.

(3 b) Home Visits

The families could be visited at home with the help of nurses and other para-medical staff. A few priliminary services can thus be rendered at home. A sort of close relationship also would be established between the health personnel and the family. The advice to be given to the family could then be given in the right perspective.

(3c) Institutional Care

Number of facilities which cannot be provided at home e.g. the curative treatment, educative programmes, maternity facilities, creache, etc., will have to be provided institutionally.

(3 d) Field Visits

Quite a few activities would necessitate field visits by the staff e.g., school check up, educational work, sanitational problems, etc.

(3 e) Family Folder

If family is taken as a unit it would be desirable to keep all the information pertaining to the family in a single file, that would facilitate proper recording and will help the staff in taking care of family in all respects and in following the progress of the family. This has been tried in the project undertaken at Poona.

(4) Activities to be undertaken by FCHC

(4 a) Medical Aid

The centre should be responsible for running a dispensary for the population allotted to the centre. The necessary staff for the purpose has been suggested (at present dispensaries exist in practically all the Municipalities).

The facilities for specialised services would vary from place to place. However the referral facilities will have to be thought

of, the outline for which has been suggested subsequently. The services of these specialists could be made available to the centres.

Domiciliary follow up for some diseases like Tuberculosis, Leprosy etc., will have to be planned.

For specialised preventive and curative services, the cases will have to be referred to the referral centre where number of special clinics could be arranged.

(4 b) MCH Services

Working plan for this activity will have to be thought of elaborately. Some of the work would be undertaken during home visits The institutional work in this activity will have to be multifaceted.

(4 b i) Maternity facility

This is the basic minimum facility that will have to be provided In the urban area trend for domiciliary deliveries would be minimal. Hence adequate institutional facility for deliveries and the maternity ward will have to be provided. (In many municipalities the maternity facilities exist). While suggesting staffing pattern this factor has been taken into consideration.

Besides maternity facility, several other facilities as discussed below will have to be provided.

(4 b ii) Antenatal Clinic

May be conducted at the centre once a week.

(4 b iii) Postnatal Clinic

(4 b iv) Well baby Clinic

This will have to be organised periodically and the babies should be followed through a preventive check up. This follow up will have to be very comprehensive and should cover effectively

an age group of 0-5 years. The check up should involve nutrition, growth, hygiene, emotional development, habit formations, personality trends, immunizations, etc.

The necessary follow up also, will have to be planned through both domiciliary as will as institutional services.

Parental education as regards bringing up the child through this age will be important. The feeling of security and love in family, as also, a proper nutrition and inculcation of healthful habits is important. This will have to be achieved through the education of parents.

(4 c) Day Care Centres for Children up to 5 years of age

Rightly this should be taken up as a part and parcel of MCH services. This service essentially will have to be divided in two

i. Creche

ii. Kindergarten School or a Balwadi.

(4 c i) Creche

This service is important especially in the case of working mothers. It can be made available for children by providing a separate room for the purpose

This activity has been proposed and implemented in the project undertaken at Poona. Also the project at Baroda has tried it and has a very logical ground for the continuation of this service.

(4 c ii) Kindergarten School or a Balwadi

This activity, is not very well developed in many places. The experts are considering the age spectrum 0-5 years as the most important period in the life of a child, from the point of view of

nutrition, physical growth, habit formation, personality development, as well as development of intellectual background. Thus, while planning health care, children of age group 0-5 years will have to be looked after adequately.

The activity of Balwadi requires collaborative efforts from health as well as educational personnel. A suitable plan for this co-ordination may be worked out.

In some states like Madras the Balwadies have been co-ordinated with MCH centres resulting in a remarkable improvement in the pre-school child care. Learning from the experience it is felt that, this sort of a co-ordination, incorporated in the function of urban health centre will result in remarkable improvement in the development of pre-school child and the child will also be better prepared for the school and thus pre-school child would cease to be an 'unwanted burden' of everybody.

(4 d) Family Planning

Linking up of F.P. programme with MCH services produces a very good dividend because if this service is rendered as a part of comprehensive health care, the couple accepts the advice very readily, because of the circumstances and the confidence in the MCH worker.

It is seen that a piece meal advice about family planning always goes astry. Given in proper perspective it readily reaches home. Thus, if medical aid, maternity and related MCH services for the population are given by a particular agency, the same agency is in a better position to talk about a small family norm, as

the agency is also following the family as a single unit.

This will also avoid duplication of services and will result in reduction in the financial requirements.

The family could be followed for F.P. purposes at home during home visits, by the nursing personnel and other para-medical staff. Institutionally, the family could be followed for F.P., while rendering other services. The postpartum sterilisation and IUCD programme could be conveniently taken up. The distribution of contraceptive also can be easily linked with MCH services.

The motivational efforts can be undertaken during all activities.

(4 e) Nutrition Programme

In the nutrition programme two aspects will have to be thought of (4 e i) in the poorer class of families, supplementing the diet of mothers (expectant and nursing) and the children upto 5 years of age, will have to be thought of. For this purpose, a feeding programme will have to be organised. This could be achieved either in clinics or through daily distribution centres.

(4 e ii) In case of middle or high income group families, education as regards nutrition will be more important. Thus a proper balancing of diet and expected intake will have to be explained to many families. This appears to be important as several committees on nutrition have time and again suggested, that, usually, an Indian diet (of rich or poor) is ill balanced. Therefore, the educational aspect as regards nutrition should not be lost sight of.

(4 f) Immunization Services

At present, small-pox vaccination services are very well established. Other immunizations are undertaken on a mass scale in few cities. In many places, getting other immunizations done is left entirely to the sweet will of the parents. This leaves many children without other immunizations at appropriate age. A family-wise follow up of immunizations will help in reducing this chance. If adequate number of vaccinators who are also trained in immunization other than small-pox, are provided, the immunizations services can be extended to every family. This will also result in better utilization of the vaccination and would also keep down the cost of the programme.

(4 g) Health Education

This should be one of the very important activities for any health service. The people have to know the concept of positive health. Otherwise, the health activities except medical care and maternity care are underrated by the very population for which these activities are planned. An adequate stress on health education would result in optimum utilisation of health services.

It need not be presumed, that health education activity need not have a priority in urban area. Knowledge pertaining to health need not necessarily be co-related with the academic education of the individual. A highly educated individual can be ignorant about many matters pertaining to health. Also urbanisation does not necessarily improve the status of knowledge as regards health.

Therefore, health education activity should deserve a priority in the comprehensive health care. It may not be treated as an

'also ran' activity.

The necessity for health education has been referred to in the proposals in the project undertaken in Poona. Inadequacy in health education facilities and materials has been stressed. In the project at Baroda also the necessity for health education has been emphasised.

In the plan of work for FCHC, health education could be made an imperative job of every worker. It will have to be done during home visits, other field visits and during institutional work. Additional efforts for health education work may be planned and a separate post of health educator may be provided for this purpose in the FCHC.

The provision of adequate audio-visual aids is important. Audio visual aids should not mean only a film projector. All the different types of aids, which could possibly help, should be thought of.

(4 g i) Nutrition Education

This will have to be treated as an important aspect, because, it would be essential to watch and improve the diet of school going child, pre-school age child and also the expectant and nursing mothers. This work will have to be undertaken during home visits. (The family budgeting would be important). In institutional services, talks, demonstrations, etc. could be planned.

(4 h) School Health

At present in several towns and cities school health programme is a separate programme. It is felt, that, if we plan to allot a limited area to the FCHC it would be better if the schools in the

area are treated as a responsibility of the same agency.

(4 h i) Projecting school child on the family surroundings

This will co-ordinate school health work in two ways. Firstly, as FCHC would be working with family as a unit the school going child can be projected back to the family surroundings. Secondly, the follow up of the child in the school as well as in the family would be co-ordinated and the performance of the child in th school can be judged into proper perspective by taking into consideration his place in his own family.

Further this would obviate the necessity for separate school health programme.

(4 h ii) Nutrition

Nutrition problem of the school going child also has to be tackled. This can be done in two ways.

(a) By supplementing diet at school

(b) By following the child at home for balancing the diet he receives at home.

(4 h iii) Referral facilities

Referral facilities as a follow up for school health check up will have to be planned and organised in consultation with referral centres.

(4 j) Sanitation

At present, the sanitation in all towns is treated as a completely separate service for all practical purposes. It does not have any relation with other health facilities like dispensary,

maternity home, immunization, etc., which are provided by the municipality. Thus a complete dissociation of santitation has been done from the rest of the health activities. A way will have to be found out to co-ordinate the santitation activity with the comprehensive health services. The present sanitary Inspector responsible for the area could be attached to FCHC. For generalised sanitation facilities a duel control could be exercised over him. This sanitary inspector could be redesignated as sanitation advisor. Thus local sanitation problem could be effectively treated by co-ordinating the sanitation service facilities with other health services rendered through the FCHC. Santitation problem could be distinctly divided in two categories.

(a) Sanitation in the house;

(b) Sanitation of the surroundings of the house and the area as a whole.

(4 j i) Sanitation within and adjacent to the house

Firstly, the problem of provision of adequate sanitation facilities for the home has to be tackled. This has to be provided by the owner of the house, if the family in question is not the owner of the house.

In case of low income group housing and the slum areas, the provision for facilities may have to be done by the concerned municipality.

Secondly, the day to day maintenance of sanitation facilities within the premises for the family and the adjacent area and the general cleanliness of home will have to be taken care of, by the family. This would involve a proper health education of the family.

The nurses, the sanitation advisor and the para-medical personnel of the FCHC will have to undertake this.

(4 j ii) Sanitation of the surroundings and the area as a whole

The provision for generalised and inter-linked sanitation facilities will have to be done by the municipality, for the town as a whole. The proper use and maintenance of these facilities becomes a more complex problem. This will have to be looked after by the FCHC.

It would be necessary to educate citizens as regards the proper use and maintenance of these facilities. The citizens will have to be made conscious of the hazards involved in improper use of these facilities.

The local maintenance required could be looked after by the sanitation advisor. The maintenance of interlinked facilities would pose a problem which will have to be solved by a liaison of the sanitation advisor with the higher authorities.

The maintenance of public sanitation facilities provided in low income areas and slums will have to be looked after by the sanitation advisor.

It is felt that the supervision of the staff like sweepers, etc., working in the project area of the FCHC could be handed over to the sanitation advisor.

(4 k) Laboratory Facilities

The facilities for routine clinical pathology work such as blood, urine and stools examinations etc. would be a great asset to the FCHC. This would reduce the work load on the referred centre and would obviate the running about of the ill.

(4 l) Vital Statistics

A thought could be given to feasibility of attaching birth death and marriage registry to this centre. Otherwise this function could be centralised for the whole town or municipality. This data would be more correct as all the families in the area are being covered by the FCHC.

(4 m) Marriage Counselling

An optional activity is suggested. This could be tried out as a project in some advanced localities.

C. EXISTING HEALTH FACILITIES IN URBAN AREA

(1) Multiplicity of activities and agencies

At present there appears to be no uniformity in the health facilities available in the urban area.

The facilities differ from state to state. The extent of facilities also depends on the size of the municipality, populationwise, incomewise.

The agencies which provide these facilities are many viz. state, municipality and voluntary organisations.

All the different facilities available in the particular town are usually not co-ordinated or are very poorly co-ordinated. The duplication of services is also a problem.

It will therefore be difficult to have a common plan of co-ordination for all these activities.

It is, therefore, felt, that, organizationally, it would be better to merge the various activities into the work of FCHC.

(2) ESIS

The service through this agency is of comparatively recent origin and it at present exists in only a few places. However, the number of facilities covered by this scheme is very large.

While planning the comprehensive health services, on the basis of family as a unit, this facility will have to be considered fully, because, this will result in a duplication of services for the families which are covered by the ESIS programme.

It will have to be remembered that these families are paying for the services they receive.

Some way out will have to be thought of, as regards integrating the services rendered by ESIS with a comprehensive health programme for the community.

(3) Available facilities

In many towns the following facilities generally exist.

(3 a) Municipal dispensaries;

(3 b) Municipal maternity homes;

(3 c) F.P. Centres;

(3d) Town sanitation establishment;

(3 e) Vaccinators;

(3 f) Malaria workers;

(3 g) Separate establishments for school health;

(3 h) Laboratory services;

(3 i) F.P. Centres, creches, balwadies, maternity homes, dispensaries; run by voluntary agencies;

(3 j) Dispensaries, maternity homes, nursing homes, etc., managed by private practitioners and consultants;

(3 k) many more different health activities may exist.

(4) INTEGRATION OF ACTIVITIES

(4a) Integration of activities

Integration of activities undertaken by municipality and state can be easily done by merging different services under the FCHC. The spheres of control by the municipality and the state could be discussed and decided upon. Further the non-existent facilities could be provided, because the services could be made more economical and more streamlined. Also the services would result in the maximum benefit for the community.

(4 b) Co-ordinating the activities of voluntary agencies and private practitioners will pose a problem. It's solution would differ from place to place.

Incidentally it may be pointed out that FCHC may not be able to undertake some of the activities for want of adequate funds. These lacunae or gaps could be filled in by the voluntary agencies. Or some fields may be left to the voluntary agencies to manage.

This planning could be done by the town co-ordination committees. The establishment of such committees as proposed by the WHO seminar on June 1970 would decidely help.

D. SIZE OF THE POPULATION COVERED BY ONE UNIT

(1) Basis for deciding population of FCHC

(1a) Individual family approach

It is proposed to render the integrated health services by considering family as a base. In that case, a personal contact and a feeling of oneness between the staff of the centre and the family is essential. The family should accept the centre staff as their friends and guides. The work to this extent will be possible, only if the centre has a restricted population to deal with. If the population is very large, this type of relationship will fail to develop.

(1b) Distance from FCHC

If the FCHC is not within an easy reach of the beneficiaries, they are likely to neglect the services rendered by FCHC. It is suggested that the FCHC may have to serve an area within a radius of a mile or two. This feeling of proximity will also result in easier acceptance of the services.

(1c) Economic Viability

Simultaneously the financial implications for the establishment and maintenance of FCHC will have to be thought of. If the unit is very small, the expenditure would be out of proportion with the services rendered.

(1d) Availability of doctors and nurses

If the unit is made too small it may, at this stage, be difficult to provide adequate number of doctors and nurses for these centres.

(1 e) Experience in some projects

This is probably reflected in the Poona project where the population is about 25,000. In Baroda project each centre had been planned for about 30,000 population. The June 70 seminar of WHO has suggested a smaller unit for about 10,000 population.

(1 f) Suggestion

Considering all the above factors it may be proposed that each FCHC may serve a population of about 20,000 to 25,000.

This population would be distributed in a relatively small area.

The family approach can also work out suitably with this population.

The suggestion of 10,000 population given by the WHO seminar of June 1970, appears to be economically burdensome. It is felt, that the population to be allotted for the FCHC may be around 20,000 to 25,000.

(2) Coverage of Municipalities with less than 15,000 population.

For purposes of health facilities municipal areas with a population of less than 15,000 may be felt in the hands of the Primary Health Centres which are already functioning effectively throughout the country.

(3) Coverage of whole town with FCHC

The FCHC could be treated as a peripheral unit for the integrated health services in urban area, irrespective of the total population of the municipality.

Depending on the total population of the municipality, these centres could be one or more. The municipalities with the population above 20,000 mark may have one centre for each 20,000 population.

(4) Establishment of referral centres

For the establishment of referral facilities and specialised services the size of the municipality will have to be considered.

This had been discussed in the WHO seminar of June 1970. The seminar had classified municipalities into the following categories:

(a) Corporation;
(b) Large Municipalities; and
(c) Small Municipalities.

It is presumed that this classification is based on the population of different municipalities. However the income aspect of the municipality may not be lost sight of.

In this note, it is not proposed to discuss the details of referral facility. However, broadly it could be suggested that the municipalities having around 4 to 5 FCHCs could be expected to have one referral unit. This referral unit could provide specialised services and referral facilities for the FCHC.

For larger towns with more than one Lakh population the referral facilities will have to be more elaborate and specialised.

It will have to be specifically programmed that the larger Municipalities, should provide referral facilities for smaller municipalities.

E. PROPOSED STAFFING PATTERN FOR FCHC

If it is proposed to provide integrated health services under one roof and agency the staffing pattern will have to be formulated accordingly. The scope of activities as discussed earlier will have to be taken into consideration. Also the maximum utilisation of the staff and the economic aspect will have to be thought of.

The experience gained from the work of primary health centres also could be considered. The proposals tried out in the projects at Poona and Baroda also provide some clues.

(1) Regular Staff for the FCHC

Based on the above considerations the following staffing pattern could be proposed:-

i.	Medical officer of health (He will be I/C of the centre and will do clinical work also)	One
ii.	Lady medical officer	One
iii.	Assistant medical officer (non graduate)	One (optional)
iv.	Public health nurse	One
v.	Health visitors (One for each 5000 population)	Five
vi.	Midwives (Health visitors may work as midwives rotationally)	Two (Optional)
vii.	Balsevika (For creche and Balwadi) (Should do liason work between FCHC and different balwadies in the area)	One
viii.	Sanitation Advisor (Sanitary Inspector)	One
ix.	Health Educator	One
x.	Vaccinators (Who should undertake all immunigation work)	Two
xi.	Pharmacist	One
xii.	Laboratory Technician	One
xiii.	Clerks	Two
xiv.	Statistician	One
xv.	Malaria worker	One (optional)
xvi.	Dresser	One
xvii.	Ayah (for creche and maternity ward)	One
xviii.	Sweeper	Two
xix.	Other class IV servants (3 male, 3 female)	Six
xx.	Additional staff as per necessity	

(2) Specialised Services

The services of specialists from referral centres could be periodically made available to the FCHC.

The consultants practising in the area could become available periodically. A suitable honorarium for them could be given.

Specialised services from voluntary agencies could be availed of.

(3) Additional Services

Additional staff or facilities may become available in the viscinity of medical colleges or teaching institutions. If any of the centres is being used as a training centre the pattern of staff and work would necessarily change to some extent.

(4) Staff at Referral Centres

The staffing pattern for referral centres and the plan of work for these centres is not being considered in this note. However, it could be added that this pattern would have a considerable reflection on the work of FCHC.

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FAMILY STUDY PROGRAMME
AND
FAMILY CARE PROGRAMME

(Dr.L.Kant, Professor of P.S.M.,
Nalanda Medical College, Patna).

INTRODUCTION.

Students are to be trained in the task which they are directed to perform under the circumstances they have to work. Distribution and delivery of the quality of medical care requires improvement. Physician must be trained in the environment in which he is actually and eventually going to work. Method of application must be adopted to the situation in which it is to be applied. Such a programme is a trend in medical education which brings student in contact with the families children and not with the patient only for their health and diseases. Family study method lends it to use as a multipurpose learning device. It provides experience to future Doctors in their relations with members of the allied health programme.

PURPOSE:

1. To acquaint the medical students with the contact of using the family as the unit for study rather than the individual patient.
2. To show how physical, social, economical, nutritional occupational and other environmental factors influence health status of families.
3. To demonstrate how illness is an individual effects other members of the family group.
4. Health Education in the family and Family planning & its importance.
5. To have complete understanding of the individual and his health in the context of the family environment.

6. To study circumstances under which a given disease occurs. Patients are segregated in the Hospitals from their environment removed from the circumstances under which they become ill, separated from their families stripped even of their clothes. Personal-health, one's relations to other family members and with the community.

7. To provide students with the opportunity to observe prenatal, natal & post natal care besides the dynamic nature of human growth and development. To assist the student in starting to establish an adequate relationship with his family, within the concept of physician in family relationship. Immunisation of children is to be done.

8. To acquaint the family with community health resources of the Government.

9. To provide an opportunity to the student physician to realise that his responsibilities not only to his patient but should also be to their families and to the community.

10. To study morbidity & other health problems in the family.

HOW LONG:

The study of the family covers about 3½ years from the first year to 4th year. The student is an observer of the entire family and of all things that arise within the family.

1ST YEAR

A general meeting should be held to discuss the programme with the leaders of the community. The student should be introduced to the head of the family selected for him to follow. The student will study the physical, social and other environmental aspects. He is an observer of the illness of the family members under the guidance of advisor of the health programme.

2ND YEAR

The students will continue the family. He helps in health and disease and observes the pre-natal, natal andpost-natal care of the maternity and observes the growth and development. To immunize the children.

3RD YEAR

Complete social and medical history is to be written. Diet and nutrition in the family is to be studied and improvements to be made. The student will help in medical care at the out-door or at the hospital,clinics. Preventive measures against infectious diseases will also be taken.

4TH YEAR.

Treatment of minor illness with approval of supervisor and preventive immunisation and first aid etc. are to be given by the student. These students had over the family to the first year students and continous medical care.

Even during the period family care is continued by the senior students at the out door or special clinic.

Family care clinic will meet once a month. The data of the family or the member of the Family will be introduced to the staff of the family care Unit. Seminar is used to summerise and promote discussions of the family Health Programme through multi-disciplinary approach. This will provide an opportunity for the students to assume gradually increasing responsibility for the medical and related problems and ultimately to help in the practice of comprehensive medical care which is the ultimate goal of the medical education.

But the student need close and constant supervision of the teachers of the Departments of preventive and social Medicine and General Medicine.

FACILITIES USED IN THE FAMILY STUDY.

Out patient clinic for the Family Care Programme.

PERSONNEL OF FAMILY STUDY.

Staff of preventive and social medicine including medical social worker and health Educator.

PREPARATION FOR THE FAMILY STUDY PROGRAMME.

A family Folder having the family record is to be given to the student and purpose and work are explained to them.

A written report of Pilot Family Programme by the student should also be submitted in the end. A summary of the Family medical problems, health problems and what the student has done for the family. He should also mention what Government agencies were contacted for the help of the families.

INDIAN INSTITUTE OF PUBLIC ADMINISTRATION
(Centre for Training & Research in Municipal Administration)
Indraprastha Estate, New Delhi-1.

GENERAL DISCUSSION
under Chairmanship
Dr. L. Kaur

Skeleton Staffing Pattern of the Pilot Community Health Centre Project

Some of the staff and equipment may be lessened according to the existing facilities available in the municipality or by Health and F.P. Department. In case the local medical college or colleges join the project for training purposes, some of staff may be reduced on account of services rendered by the students and in return conveyance may be given to the college. But driver and recurring cost to be met by the college.

Administrator

He should be a medical man with P.H. qualification and experience. Preference will be given in case he has teaching and research experience. His status will be that of an Associate Professor of a medical college.

In addition to the administrator, in case Medical College also joins the team, the Prof. of P.S.M. will be an adviser and will help in supervision, training and research. He will be allowed a remuneration for this. His students will work and accordingly some staff may be reduced.

Staff:- 1 with 15 maternity beds.
without diet or linen.

1. Medical Officers - Chief — Medical Officer

The general plea made was that where the services were fragmentary, gaps should be filled and a minimum floor of services should be ensured in an overall integrated pattern.

3. Comprehensive maternal and child health/family planning services was the subject of a seminar organised by the World Health Organisation's Regional Office for South East Asia, at New Delhi, in June, 1970. The WHO Regional Office had also organised earlier another Seminar on Integration of Maternal and Child Health Services into General Health Services, at New Delhi, in February, 1970. The conclusions and recommendations of this earlier seminar are given in Annexure I. Annexure II gives extracts from an article on the subject by Dr. Franz Rosa of World Health Organisation, Geneva, presented at the Delhi meeting held in June, 1970. Annexure III gives some extracts from the recommendations of the Seminar on Comprehensive Maternal Child Health/Family Planning Services held in June, 1970. A brief note on "Inexpensive Family Planning and Health Programme" published in the Participant Journal of May, 1971 is given in Annexure IV.

4. The first WHO Seminar held in February, 1970, erphasised that "Maternity and Child health should be identified unit for policy, planning, programme implementation and evaluation". It was also stated that "because family planning is an essential part of health care provided for mothers, children and families, it should be provided as an integral part of maternal and child health services". At the Second Seminar (June, 1970) "discussion brought out the importance of a balanced development of maternal and child health and family planning programmes,

mutually supporting and reinforcing each other". It was also pointed out that "The multiplicity of agencies and authorities which is characteristic of urban maternal and child health and family planning work creates very difficult problem of coordination". There appears to be an overwhelming opinion in favour of integration but it was noted that "Even though government policy to integrate maternal and child health and family planning has been stated in general terms, there is a good deal of difference of opinion about how to put the principles of integration into practice". It is necessary to work out some alternative models that can be given a fair trial.

5. The C.M.A. is confronted with the task of drawing up proposals for family and child health centres as a basic part of a plan of integrated services to children and youth in urban areas. Both in Lucknow and Baroda, for which preliminary proposals have been prepared, an integrated family and child health centre finds a prominant place. Annexure V gives some details about the activities proposed to be undertaken by such centres and their staffing and budgetary patterns. At Poona, the B.J. Medical College and the City Municipal Corporation are cooperating together to provide such services although they would like the arrangements and facilities to be somewhat more complete. A brief note on the Poona Urban Health Centre is given in Annexure VI.

6. It has been considered appropriate to organise a consultancy meeting so that the C.M.A. may have the benefit of expert guidance in developing models for organisation of family and child health centres under the programme of integrated services to children and youth in

urban areas. This meeting may, therefore, discuss and workout proposals in respect of the following and other relevant matters that might be identified:-

a) Scope of activities to be undertaken by family and child health centres and the extent of integration of such activities as are carried out by different agencies;

b) Size of the population that may be covered by one unit of Family and Child Health Centre (FCHC);

c) Staffing patterns for Family and Child Health Centre, with due regard to effective performance and economy;

d) Budgetary aspects - non-recurring and recurring of a FCHC; and

e) Administrative arrangements of a FCHC. etc.

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ANNEXURE - I

THE INDIAN INSTITUTE OF PUBLIC ADMINISTRATION

Centre for Training & Research in
Municipal Administration
New Delhi

Project on Integrated Services to Children and Youth in Urban Areas

RESTRICTED

Extracts from

REPORT OF THE SEMINAR ON INTEGRATION OF MATERNAL AND CHILD HEALTH SERVICES INTO GENERAL HEALTH SERVICES

Held in New Delhi

From 2 to 7 February, 1970

(WHO Project: SEARO 0173)

Extracts from

REPORT OF THE SEMINAR ON INTEGRATION OF MATERNAL AND CHILD HEALTH SERVICES INTO GENERAL HEALTH SERVICES

Conclusions and Recommendations

1.1 Organisation and Delivery of Services

(1) Maternal and child health should be an identified unit for policy, planning, programme implementation, and evaluation at national and intermediate levels, and in large urban (and suburban) areas. This is essential in order that the special needs of mothers and children be taken into consideration and provided for, whenever health programmes for the general population or for any particular segment of it are being planned and carried out.

(2) All mothers and children should be provided with basic, essential health care, because of their increased vulnerability and hence increased needs.

(3) For those mothers and children in the "high-risk" category, additional care is essential. The most skilled resources and the most highly trained personnel should be used for high-risk patients. Screening programmes are necessary, and services should be organized to provide screening, so that high-risk mothers and children may be identified early and given the needed care.

(4) Because family planning is an essential part of health care provided for mothers, children, and families, it should be provided as an integral part of maternal and child health services. There are specific opportunities in maternal and child

health and generalhealth services in which family planning education and service may be introduced, and these opportunities should be fully utilized. Included in this are:

(a) pre-natal clinics in hospitals andhealth centres,

(b) post-partum services in hospitals and health centres,

(c) post-partum clinics in hospitals and health centres,

(d) services for women who have had an abortion,

(e) gynaecology services,

(f) well-child clinics,

(g) paediatric out-patient clinics and in-patient services,

(h) rehydration services,

(i) nutrition rehabilitation units,

(j) services for handicapped childre,

(k) day-care centres,

(l) school-health services,

(m) tuberculosis services,

(n) venereal-disease clinics, and

(o) occupational health services

(5) Because of the prevalence of neonatal tetanus in some countries of the Region, tetanus toxoid should be given to pregnant women, especially those living in known endemic areas. It is most important that the hygienic handling of the umbilical cord be emphasized. Particular attention should be placed on the training of traditional birth attendants in regard to this.

(6) Priorities in immunization programmes should be established in each country, based on special epidemiological characteristics, resources, and facilities ofthe country.

(7) Because of the high prevalence of acute diarrhoeal diseases among infants and children in the Region, more intensive efforts are needed to improve environmental sanitation and health education of parents. It is recommended that rehydration facilities, including oral rehydration, be provided as part of maternal and child health care in health centres as well as outpatient clinics of community hospitals.

(8) Since traditional birth attendants in most countries of the Region are involved in the care of mothers and children, it is essential that they received appropriate training on a continuning basis. It is equally essential that auxiliary and professional health workers understand the role of and need for traditional birth attendants and develop a close working relationship with them.

(9) Those countries in the Regional which do not yet have nutrition rehaibilitation units or centres should establish them as part of their maternal and child health services. These units should be evaluated and eventually extended to all parts of the country. A high priority should be given to the establishment ofnutrition rehabilitation centres in teaching institution.

(10) Because of the high prevalence of malnutrition among women of child-bearing age, the high incidence of low birth-weight infants and the importance of breast-feeding, it is recommended that emphasis be placed on improved nutrition of adolescent girls and of pregnant and lactating women, including the routine administration of iron tablets and other nutrients as necessary.

(11) There is urgent need for the introduction of suitable locally available weaning foods.

(12) With a view to improvement the health of school-aged children and improving the school-health programmes, inter-departmental committees, composed of representatives of health and education departments and of the community be established at all levels.

(13) Because of the importance of the role of the teacher in health education, in observing deviations from the normal and in providing simple first aid, it is recommended that a manual suitable for use by teachers should be developed in each country. In this task, the technical guidance of international organisations might be sought.

1.2 Education and Training of Personnel

(1) Maternal and child health and family planning should be an important and integral part of the training of all health workers, at both undergraduate and post-graduate levels.

(2) It is essential that all health workers, especially those dealing with mothers and children, receive in-service training in family planning, within the framework of maternal and child health and general health services.

(3) Since teaching institutions are responsible for training workers for the health services, there should be close cooperation between the authorities responsible for the teaching and those responsible for the services. In the field of maternal and child health, close cooperation is essential between the teaching staff of the departments of paediatrics, obstetrics and preventive medicine, and the public health authorities, especially those responsible for maternal and child health and family planning services.

(4) To obtain a more adequate provision for the care of mothers and children there is an urgent need to traing and employ more auxiliary health workers.

(5) Emphasis should be placed on appropriate training of all health workers in nutrition so that whenever they come into contact with mothers and children in homes, hospitals, and clinics, they can use the opportunity for education, especially in the practical guidance of feeding of families.

1.3 Activities for which International Assistance might be sought

It is recommended that the following activities, in which international assistance might be sought, should be undertaken by countries in the Region:

(1) Preparation of manuals or guidelines for field workers and supervisors in maternal and child health;

(2) The planning and development of demonstrations of integrated maternal and child health and family planning services within the framework of general health services;

(3) Studies on (a) the relationship to each other of parity, gravidity, interval between pregnancies, and the physical and mental health of mothers, children and other members of the family, and (b) the problems associated with the integration of maternal and child health and family planning services into the general health services and the possibilities of developing a health service simulation model, and

(4) Provision of opportunities for key maternal and child health and health administrators to observe and study integrated maternal and child health services in the Region.

ANNEXURE NO. II

Maternal and child health and family planning programmes in urban areas by Dr. Franz Rosa

The immediate health problems of mothers and children are important and must be looked after. But this does not mean that we must face problems. Prevention is always better than cure.

The WHO expert committee adopted the child health objective that "every child live and grow up in a family unit, with love and security in healthy surroundings receiving adequate nutrition, health supervision and sufficient medical attention and be taught the elements of healthy living." For maternal care the objective adopted is "to ensure that every expectant and nursing mother maintains good health, learns the art of child care, has a normal delivery, and bears healthy children." Maternity care therefore consists in pre-natal and post-natal care. It also includes the problems of infertility and family planning.

A basic principle of maternal and child health is the close inter-relationship between the two. Unless maternal care and child care are coordinated many of the most important problems of both will fall in the self created gap.

Urbanisation is a major aspect of faily health. Inadequate distribution of health services is posing a problem which must be tackled immediately of course there is lack of coordination between isolated family planning clinics and maternal and child health clinics as well as separate maternity centres in some cities. Overloaded maternity services carry with them the problem of nursery congestion and the concomitant hazards of epidemics of diarrhoea and infections of the newborn.

The city has many advantages over the rural area. The services generally reach people more easily in urban than in rural areas. Concentrated urban services should therefore be able to cover the bulk of the population. Systematic immunisation must get our attention. Every new born must get BCG followed by small-pox and other immunisations on an early, practical schedule. An approach through school health programmes will have more impact as it will easily cover the school going population. Large maternity services are places where large numbers of women can be reached conveniently and given education regarding family planning.

The planning of urban maternal and child health/family planning programmes must be based on careful and continuing evaluation and coordination with the overall health, social and economic context of the community in order to ensure the efficient development and distribution of maternal and child health skills, facilities and services. Over principal objective is to adopt the basic health services to specially meet the needs of mothers and children.

The maternal and child health/family planning administrative unit at the community level must ensure that policy and planning will cover the needs. They can get help from advisory bodies which draw their numbers from other interested units such as education, welfare, social services etc. These committees can play a useful role in guiding the responsible MCH unit in pointing out special problems and helping to assess the effectiveness of the services. The Unit can serve as a focal point for maternal and child health information and activities and it can have research projects along with in service training facilities. It can look after distribution of resources and

recommend legislation to support particular programmes. It may be responsible for administering directly certain large central maternity and paediatric facilities.

The peripheral unit has the responsibility of recognition and primary management of the common health problems of the area. Their most important job is to provide elementary health education with special emphasis on family planning nutrition, hygiene, child bearing and child rearing.

The peripheral unit will not be able to handle all of the problems so they should set up an approach to screening mothers and children in order to identify those who are at particularly high risk and require referral to more qualified facilities. The peripheral unit may serve as a point of contact for arranging attendance for itinerant specialised services.

If Family planning activities are integrated with MCH Serviced it would be of great help. Actually both maternal and child health and family planning are directly concerned with the health of the individual mother and infant and with the physical and social health of the family. Funds can be pooled for the ultimate strengthening of both activities. Personnel can be used to provide broaden services to reach the population more effectively, making it possible to provide more comprehensive care at lower cost to the community as a whole. Duplication, fragmentation and competition are avoided.

Some very encouraging family planning efforts have been developed in the large maternity services of urban hospitals. It has been shown that family planning advice can be related conveniently to nutrition concerns and nutrition counselling

since maintenance of lactation, adequate child spacing and adequate family resources for nutrition are all related to family planning. The school health programmes should not be narrowly conceived as being concerned only with the health of school children. The main concern should be with developing healthful habits and imparting health education for the formation of lifelong individual health, for imparting healthful family life attitudes, and for developing strong community health attitudes. The maternal and child health programme must be broad enough to cover the needs of school going as well as non-school going children. Continuity of services should be available during pre-school period too.

Youth is a particular area of concern in family health because it is a period when the child is leaving his own family, with all the necessary adjustments, and is involved in planning his own future family. It is therefore important to train children in such a way that they are able to meet their needs with realistic job preparation and concrete job prospects in the community. Maternal and child health workers should be able to coordinate this point with education so that the youth do not have difficulty in adjusting himself in the new environment.

(2) It is essential that all health workers, especially those dealing with mothers and children, receive in-service training in family planning, within the framework of maternal and child health and general health services.

(3) Since teaching institutions are responsible for training workers for the health services, there should be close cooperation between the authorities responsible for the teaching and those responsible for the services. In the field of maternal and child health, close cooperation is essential between the teaching staff of the departments of paediatrics, obstetrics and preventive medicine, and the public health authorities, especially those responsible for maternal and child health and family planning services.

(4) To obtain a more adequate provision for the care of mothers and children there is an urgent need to traing and employ more auxiliary health workers.

(5) Emphasis should be placed on appropriate training of all health workers in nutrition so that whenever they come into contact with mothers and children in homes, hospitals, and clinics, they can use the opportunity for education, especially in the practical guidance of feeding of families.

1.3 Activities for which International Assistance might be soug

It is recommended that the following activities, in which international assistance might be sought, should be undertaken by countries in the Region:

(1) Preparation of manuals or guidelines for field workers and supervisors in maternal and child health;

(2) The planning and development of demonstrations of integrated maternal and child health and family planning services within the framework of general health services;

(3) Studies on (a) the relationship to each other of parity, gravidity, interval between pregnancies, and the physical and mental health of mothers, children and other members of the family, and (b) the problems associated with the integration of maternal and child health and family planning services into the general health services and the possibilities of developing a health service simulation model, and

(4) Provision of opportunities for key maternal and child health and health administrators to observe and study integrated maternal and child health services in the Region.

ANNEXURE III

EXTRACTS FROM THE REPORT OF THE MEETING
ON
COMPREHENSIVE MATERNAL AND CHILD HEALTH/FAMILY PLANNING SERVICES
IN
URBAN MEDICAL AND HEALTH INSTITUTIONS IN INDIA
HELD IN NEW DELHI FROM 1 TO 4 June 1970
(WHO PROJECT: INDIA 0250)

(Not to be circulated).

4. KEY CONCEPTS BASIC TO AN INTEGRATED MATERNAL AND CHILD HEALTH/FAMILY PLANNING PROGRAMME

4.1 The Rationale of Integration

A number of reasons why the services of maternal and child health and of family planning should be provided in an integrated fashion were discussed and agreed upon in the meeting. These are summarized below.

4.1.1 Survival of Children

Survival of children strongly affects motivation for family planning. If parents can have assurance that children born alive have a good chance of survival, the parents are much more likely to accept family planning. If such assurance is lacking, as it must be in areas of high infant and child mortality, the "over production" of babies is inevitable. Examples of the problem, probably not atypical, came during the discussions, when Madurai reported that 44% of all deaths were under five years of age. From Lucknow came the report that about 45% of children born alive were dead at the time that a family survey relating to family planning was made.

4.1.2 Advice by maternal and child health staff

Family planning advice is more acceptable when it comes from trusted maternal and child health workers.

People are less likely to accept advice on family planning from workers who appear to be 'unconcerned' about general family welfare problems.

4.1.3 Economy

Integrated services are more economical.

When provided in an integrated manner, the components of service may be provided more economically than if given separately.

Also, in the educational sense, "re-inforcement" is furthered.

4.1.4 Professional interest

This is greater with integration. An integrated programme presents greater professional interest and challenge than does a segmented approach, and this aids in the recruitment and holding of doctors, nurses, etc. The epithet "loop doctor" is avoided.

4.1.5 Opportunities for family planning provided by maternity care

Every phase of maternity care opens up chances for motivation for family planning. The post-partum programme in hospitals is a very good example.

4.1.6 Comprehensive health service

Integration provides the soundest basis for comprehensive health service to the whole person.

Responsibility is not divided among several agencies, so that "passing the buck", or endlessly referring the patient from one office to another, can be minimized.

4.1.7 Emphasis given to preventive medicine

Integration makes an emphasis on true preventive medicine more likely and more readily attainable.

4.1.8 Possibilities of obtaining a balanced programme

Integration favours a balanced community health programme.

A single officer who is responsible for the total health budget of the community is in a position to see to it that services for primary prevention are not financially starved by over-emphasis on secondary prevention activities; proper priorities may be given in the light of all available facts.

4.1.9 Strengthening of health services

Integration strengthens the competitive position of health services among the galaxy of governmental agencies, since the total operation is more extensive, and has a larger budget (than would be the case of two or more separate health agencies, one concerned with medical care of the sick and the other with conventional public health, etc). A single person who is able to speak for the whole health service of the community will normally carry more weight than would two or more separate spokesmen for health.

4.1.10 Rapprochement of preventive and curative services

Integration is biologically logical.

So called "preventive" and "curative" services may not be logically put into separate water-tight compartments by anyone who is familiar with the natural history of disease.

4.2 Definitions

It was agreed that three words were of special importance to the meeting, and that there should be a clarification of their meaning, if participants were to understand each other and if the discussion were to be fruitful. These "key words" were:

"integration"
"comprehensive care", and
"co-ordination".

4.2.1 Integration

The meeting accepted the working definition of integration that had been adopted by the Indian National Institute of Health Administration and Education(NIHAE) in the studies of the Institute, i.e.,

The term "integrated health services " means:
"A health service which has a unified rather than a segmented approach in dealing with health problems. "Medical care of the sick" and "conventional" public health programmes are:

> Under a single director or administrator Operated in a unified manner at all levels of the hierarchy So planned and executed that they fit together in a dovetailed fashion so as to be complementary to each other, and so that the needs of both sick and well are looked after. Each is given the priority it deserves, so that a balanced community health programme results."

It was noted that the preliminary NIHAE studies had revealed important differences in ideas about the implementation of integration among NIHAE faculty members and among the States(samples of administrators in eight States were studied). (The differences were not so great on agreement with general statements about the basic meaning of the concept of integration,but serious differences were found when those interviewed were asked to sort out some two dozen organizational charts into piles representing those which "would facilitate integration"and those which "would NOT facilitate integration".)

It seemed quite clear that the degree of confusion was sufficient to suggest caution in use of the word"Integration", and that there was a need for careful in-service education by organizatans wishing to "integrate" their services.

Perhaps the most important thing that might be said about integration is that it depends on the state of mind of the workers. If the workers really understand and accept the ultimate objective of providing integrated services to the people rather than having a neat-looking organizational chart,

the project is very likely to succeed, even in the face of organizational obstacles.

RECOMMENDATION

Family planning and maternal and child health services should be integrated.

4.2.2 Comprehensive care

The participants agreed that "comprehensive" health care, or "comprehensive" maternal and child health services, or "comprehensive" family planning services might be said to include:

(1) Essential basic health services, at all levels of prevention

Moreover, care should be available as it needed to deal effectively with the sequence of needs occurring in the course of the developing natural history of the various common community health problems.

Such types of care should include those which may be classified under the various levels of prevention (and other terms with similar meaning):

Levels of prevention	1 Health promotion	2 Specific protection	3 Early diagnosis and prompt treatment.	4 Limitation of disability	5 Rehabilitat
Hilleboe and Larimore	Prevention of occurrence		Prevention of progression		
D.Seegal	Primary prevention		Secondary prevention		Tertiary prevent

(2) Continuity of care,
(3) Availability of care when and where needed, and
(4) Absence of serious financial barriers to care.

4.2.3 Co-ordination*

The question of co-ordination had two aspects which were important for this meeting:

*The word "co-ordination" was suggested by one of the participants as being of equal importance with "integration" and "comprehensive", and the meeting accepted this addition.

(1) Co-ordination with administrative control. This is a normal function of management within an organization, the necessity for which is generally accepted.
(2) Co-ordination without administrative control. It is this aspect of co-ordination which is so important for the integrated urban maternal and child health/family planning programme because of the multiplicity of authorities and agencies involved - governmental, voluntary and private. When there is no administrative control, co-ordination must be accomplished by persuasion rather than by directive.

At the conclusion of the full discussion on integration, comprehensive care and co-ordination, the participants took note of the views expressed by the representative of the United Nations Advisory Mission (1969) on the Family Planning Programme in India, who had this to say about integration:

"the Government of India has associated the family planning with its health services, particularly with maternal and child care services (maternal and child health). The Mission agrees that the period of pregnancy and the post-partum stage are highly suitable for family planning motivation and that increasing assurance of child survival will induce parents to accept the small family norm. Even the enlarged network of health services is, however, still far from adequate to cover the country. Needless to say, the acceptance of the small family norm depends also on the quality of the available health services." "the Mission strongly supports this linking of family planning in India with maternal and child health. It should be emphasized that, both quantitatively and qualitatively, the services need to be strengthened in respect of physical facilities, equipment, vehicles, drugs and other supplies. The Mission feels that opportunities for external assistance exist in these fields and could contribute greatly to sustained and rapid progress"

5. ORGANIZATION PATTERNS TO FACILITATE INTEGRATION OF MATERNAL AND CHILD HEALTH/FAMILY PLANNING IN URBAN AREAS

5.1 Present Patterns of Organization

In rural areas an organizational approach has been developed through primary health centres, with the intention of covering the entire population with family planning and maternal and child health services. However, no such generally accepted patterns for organizing services have developed in urban areas which differ greatly among themselves in total population and in other "situations".

In urban areas, a number of agencies, like (a) the health organizations of the urban local body, (b) those of the State Government, (c) the trust agencies (i.e., voluntary and co-operative organizations) and (d) private nursing homes and practitioners, are operating. Quite often the activities of the first three overlap. There is very little, if any, co-ordination amongst their activities. Further, the type of services available differs widely from one urban body to another.

For the present purposes, urban communities may be divided into the following major categories:

(a) Corporations
(b) Large municipalities
(c) Small municipalities

RECOMMENDATION

Patterns of organization should be evolved which will facilitate the integration of maternal and child health and family planning in urban areas with different populations and situations.

5.2 Programme of Services

The organization required will, of course, depend on the programme of services to be provided. The "level" of services may be thought of as:

(1) "Irreducible minimum" (The irreducible minimum is intranatal services and the immunization programmes):

(2) The present situation, and

(3) "Graded" steps towards the ultimate development of comprehensive maternal and child health services and comprehensive family planning services. (These "graded steps were not discussed in detail in the meeting.)

5.3 Organization Required

To obtain maximum results with the "inputs" at present available, the following type of organization was suggested:

5.3.1 General objectives

These would be:

(a) To provide integrated family planning and maternal and child health services.

(b) To provide complete coverage geographically.

(c) To provide services of different degrees of specialization to deal with different needs such as normal pregnancies and complicated pregnancies.

(d) To provide optimum utilization of specialist services which are in short supply.

(e) To provide referral services between units operating at different levels of specialization.

(f) To provide co-ordination among agencies of different levels of specialization as well as among agencies responsible to different authorities.

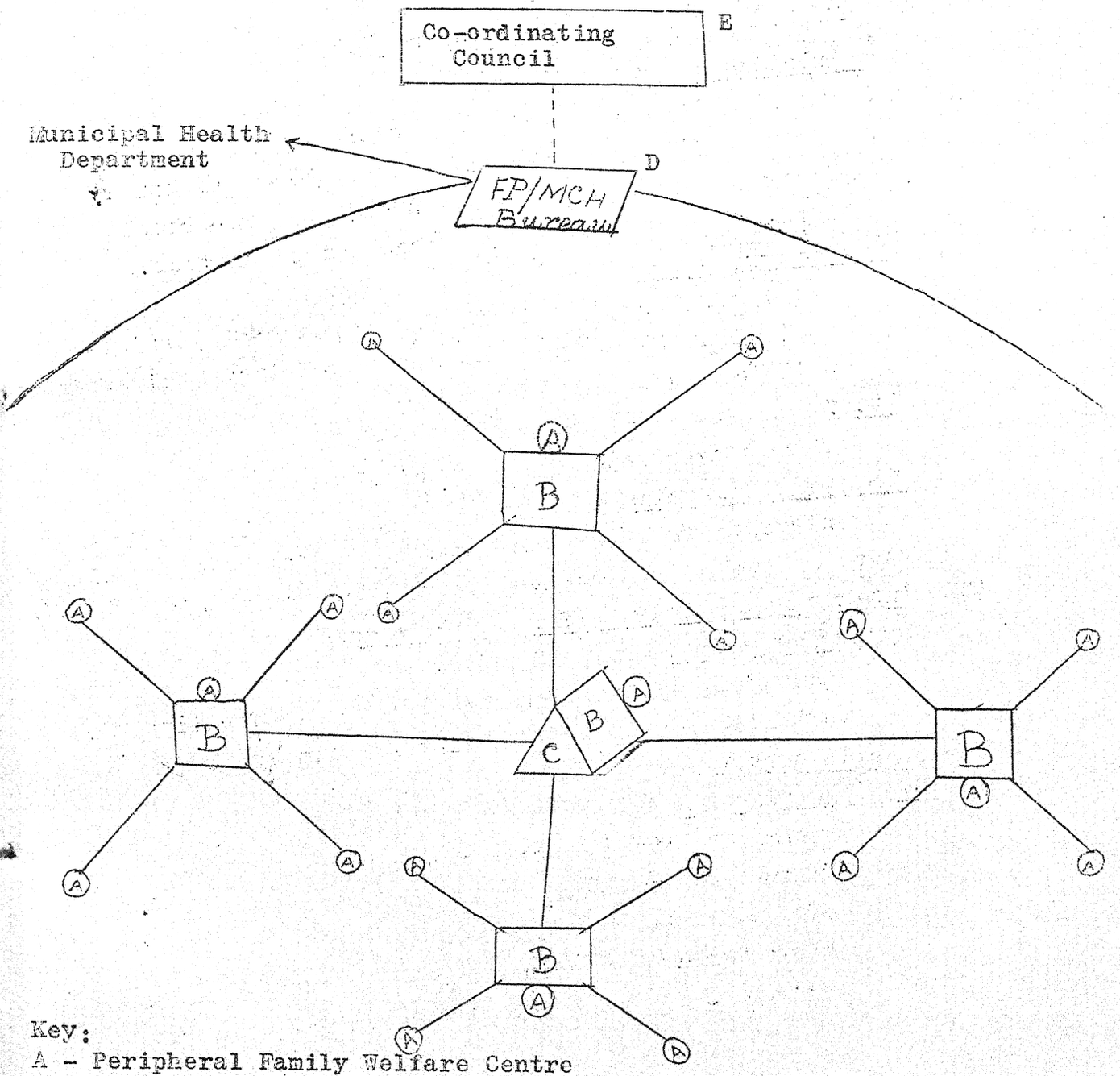
(These objectives correspond closely to the widely used concept which generally is referred to as "regionalization of health services.")

5.3.2 Pattern

The general pattern of organization is illustrated in the diagram on the following page, which includes: (1) peripheral family welfare centres, (2) intermediate family welfare facilities, (3) one or more central family welfare facilities, (4) a city maternal and child health/family planning bureau, and (5) a family welfare co-ordinating council.

URBAN MATERNAL AND CHILD HEALTH/FAMILY PLANNING SERVICES

Organizational Pattern



Key:

A - Peripheral Family Welfare Centre
B - Intermediate Family Welfare Facility
C - Central Family Welfare Facility
D - City Family Planning/MCH Bureau
E - Co-ordinating Family Welfare Council

Some other important details of each element of the organization are as follows:

(1) Peripheral Family Welfare Centres(A)*

Population served

About 10 000, which would include 40 deliveries per thousand population,150 couples "eligible" for family planning per thousand population and 150 pre-school children needing services per thousand population.

Services provided

Educational,motivational and promotional services
Domiciliary visits,including domiciliary deliveries
Clinic or out-patient services

Staff

Generalized rather than specialised

Inter-relationships

Screening,to sort out complicated cases from the normal ones Referral of complicated cases for more specialized care

(2) Intermediate Family Welfare Facilities(B)

Population served

Approximately 50,000,Each intermediate facility will work with four or five peripheral family welfare centres.

Services provided

Services of intermediate complexity
Laboratory services
Deliveries of normal cases
BCG and smallpox vaccinations
Supervision of peripheral family welfare centres

Staff

More specialized than that of the peripheral family welfare centre but less so than the staff of the central family welfare facilities.

Inter-relationships

"First line" for referrals from peripheral family welfare centres Referral of more complicated cases to central family welfare facilities.

(3) Central Family Welfare Facilities (C)

Population served

Approximately 250 000,since each central family welfare facility will work with four to five intermediate family welfare facilities. The number of central family welfare facilities required will depend on the total population of the urban area. Only the larger urban areas will require more than one.

Services provided

Specialized services to deal with complex cases or situations May have special postpartum programme Education and training of maternal and child health and family planning workers' research

Staff

Specialized

Inter-relationships

"Second line" for referrals from peripheral family welfare centres or from intermediate family welfare facilities. Referrals back to intermediate facilities or to the family welfare centres.

(4) City Maternal and Child Health/Family Planning Bureau (E)

This bureau will have inter-relationships with the urban Health Department, usually serving as a bureau to that department. It will also have relationships with all the agencies in the particular urban area which provide maternal and child health family planning services. It will also work with the overall Family Welfare Council, serving it in a kind of staff capacity.

5.4 Nomenclature

RECOMMENDATIONS

(1) All personnel employed at present in maternal and child health work and those employed in family planning should be redesignated as personnel for maternal and child health and family planning.

(2) The integrated family planning and maternal and child health centres may be called family welfare centres.

6. PATTERNS OF FUNCTIONAL INTEGRATION

6.1 Agencies (Governmental and Private)

It has already been noted that large numbers of large agencies and authorities, as well as private practitioners, are involved in providing family welfare services to the total urban community.

RECOMMENDATIONS

In order to secure effective co-ordination among the activities of existing multiple agencies in urban areas, there should be a Family Welfare Council.

This Council should have the following composition and functions:

Corporations

(1)	Commissioner of Municipal Corporation	- Chairman
(2)	Representative of State Medical and Public Health Department	- Member
(3)	Representative of trust bodies	- Member
(4)	Representative of the local Indian Medical Association	- Member
(5)	One representative of the Grants Committee	- Member
(6)	The Chief Health Officer or his specified nominee	- Member (Secretary)
	(The Council may co-opt members)	

Large Municipalities

(1)	President/Administrator of Municipality	- Chairman
(2)	District Family Planning (and MCH) Officer	- Member
(3)	Representative of the trust bodies	- Member
(4)	Representative of Indian Medical Association	- Member
(5)	The Principal Medical Officer of Health of the Municipality or the Chief Executive Officer if there is no medical officer	- Member (Secretary)

(The Council may co-opt members)

In case of smaller municipalities who do not provide family planning/maternal and child health services, the State health department should provide them.

The Family Welfare Council might follow the following guidelines in carrying out its functions:

(i) Promote the family welfare

(ii) Advise on location of family welfare centres

(iii) Review the progress of the programme

(iv) Suggest lines of co-ordination between dispensaries and the family welfare centres.

(v) Recommend other mechanisms of co-ordination, and

(vi) Select the organization/agency which should follow up on the Council's recommendations.

6.2 Other Co-ordinating Mechanisms

RECOMMENDATION

Urban bodies should send information about the progress of their health, family planning and maternal and child health programmes periodically to the district health authorities concerned.

ANNEXURE - IV

A model plan of action

INEXPENSIVE FAMILY PLANNING AND HEALTH PROGRAMME

A comprehensive approach to family planning control and maternal-child health care for the developing countries, which the authors say would cost only 60 cents a person a year, was announced by the Population Council in a New York press conference last month.

The plan is based on a two-year study conducted in nine nations including India. In suggesting a model plan of action and putting a low price tag on the costs of operation, the authors believe that millions of births can be averted in heavily over-populated areas of the world and at the same time the health of mothers and children improved.

Dr. Howard C. Taylor, Jr., former director of the International Institute for the Study of Human Reproduction at Columbia University and now consultant to the Population Council, and Dr. Bernard Berelson, president of the Council, conducted the study under a grant from the Commonwealth Fund.

The key to the success of their proposed programme, particularly in the rural areas where proper health delivery is now lacking, is the training of midwives to offer professional care, they told newsmen. They estimate the total cost of the programme for all of the developing countries with the exception of Mainland China, at a billion (thousand million) dollars a year. Whether this would be the most effective and least expensive way to achieve fertility control in the modern world, the authors could not say. With the help of Population Council they now seek appropriate opportunities to initiate field demonstrations to test out the plan in practice.

The feasibility study announced in New York was worked out with collaborators in each of the participating countries - Colombia, Ghana, Kenya, India, Iran, Turkey, Indonesia, the Philippines and Thailand. They found one of the most effective and least expensive ways to teach family planning is to tie it to pre-natal and post-natal care when the women are at hand to receive information and services.

While physicians must guide the overall efforts, no great increase is foreseen in the numbers of doctors needed in these countries for the programme. The key person is the nurse-midwife. Still another important aide in the plan - the village assistant or indigenous midwife - helps the auxiliary midwife both medically and by promoting contacts with the village people.

The blueprint for a rural programme calls for construction of a network of new maternal child health centres (MCH). A major centre could take care of 100,000 people or about 4,000 deliveries annually. It would include 20 beds, clinics for family planning, one physician, five supervising midwives, and supporting personnel. Feeding, into this centre would be a series of 25 sub-stations, each administering to 4,000 people or 160 annual deliveries. One auxiliary midwife, one village assistant and a family planning clinic would staff each of these sub-stations.

The urban facility, envisoned by the proposed plan, would serve 50,000 people with 2,000 annual deliveries and would have 20 beds, a family planning clinic, an obstetrician, three midwives, five auxiliary midwives and supporting personnel.

Schools would have to be established to train the additional midwives that would be required under the overall programme.

The six essential elements of the programme include two contacts with each mother prior to birth; provision for a trained attendant at delivery; three personal contacts after delivery; obstetrical and planning facilities which are accessible; a system of accurate records; and organized assistance from the village.

The plan relies on active support from the government of each participating country and its health ministry as well as acceptance at the village level alongwith wise use of facilities and extension of individual and community education.

ANNEXURE NO. V

THE INDIAN INSTITUTE OF PUBLIC ADMINISTRATION
Centre for Training and Research in
Municipal Administration
New Delhi

"Integrated Services for Children & Youth in Urban Area".

PROPOSALS FOR PROVISIONS OF HEALTH SERVICES IN PROJECT AREAS:

RELEVENT EXTRACTS FROM THE PROJECT REPORTS:-

1. LUCKNOW.

2. BARODA.

LUCKNOW PROPOSALS

Health and Nutrition - It is in this field that the services are most halting and there is need of institutional integration. The existing services in the area are limited to the following:-

1) Maternity-Centre managed by corporation - annual outlay Rs.13,000/-. This is totally inadequate.

2) Family planning clinic managed by Red Cross but housed with a municipal dispensary building - annual expenditure Rs.24,000/-

3) Vaccination services by Corporation but no other regular immunisation facilities.

4) Nutrition-programme for age-group 0-3 being administered by the Social Welfare Directorate with the help of some lady school teachers, the municipal schools being distribution points. This programme is being extended to children upto 6. There is also the proposal for distribution of Balahar to all school children above the age of 6 - now being finalised by State Education Department through the Municipal corporation.

There is no School Health Programme. Immunisation programme, nor is there any suitable arrangement for health guidance for children and mothers. The nutrition programme requires being integrated with a health check-up and immunisation service. There is need for a Family and Child Health Centre to meet these gaps and to ensure coordination and effective utilisation of services provided. The budget, for such a Centre drawn up in consultation with the Head of Department of Social and Preventive Medicine, Lucknow Medical Colleges is as follows:-

I. Non-recurring expenditure

A. BUILDING

Sl. No.	Details of the rooms	Size	Total built-in Area (Square ft.)
1.	Male Doctor's room	16'x18'	288
2.	Lady Doctor's room	16'x18'	288
3.	Public Health Nurse Room	14'x12'	168
4.	Pharmacist Room	16'x18'	288

5. Medical Social Welfare room	14'x12'		168
6. Waiting Room	20'x20'		400
7. Family Planning Clinic Health Educator	20'x40'		800
8. Specialist room - Dentist	16'x18'		288
9. Specialist room - Ophthalmic	17'x18'		288
10. Sanitary Inspector's room	12'x10'		120
11. Mid-wives room	12'x10'		120
12. Laboratory	12'x16'		192
13. Surgical room	16'x10'		160
14. Record Room 15. Office	20'x20'		400
16. Store Room	20'x20'		400
17. Lavatory: (a) 2 General (Male-Female) (b) 2 staff (Male-Female) (c) 4 attached lavatories to Doctors and Specialists.	12'x10' 12'x10' 16'x15'	 each	120 120 120
18. Immunisation room	12'x10'		120
19. Recreation (open space)	--		
20. Sterilisation room	12'x10'		120
21. Motor garage	12'x20'		240
			5,208 sq.ft.

TOTAL COST = Rs. 2,50,025
(Or say Rs. 2.5 lakhs).

B. FURNITURE

Total Rs. 55,645.00

C. EQUIPMENT

(a) Clinic Rs.21,000.00

(b) Operation Theatre Rs.1,14,750.00

D. AUDIO-VISUAL AIDS Rs. 56,300.00

E. VEHICLES: Rs. 50,000.00

TOTAL NON-RECURRING EXPENDITURE Rs. 5,47,720.00

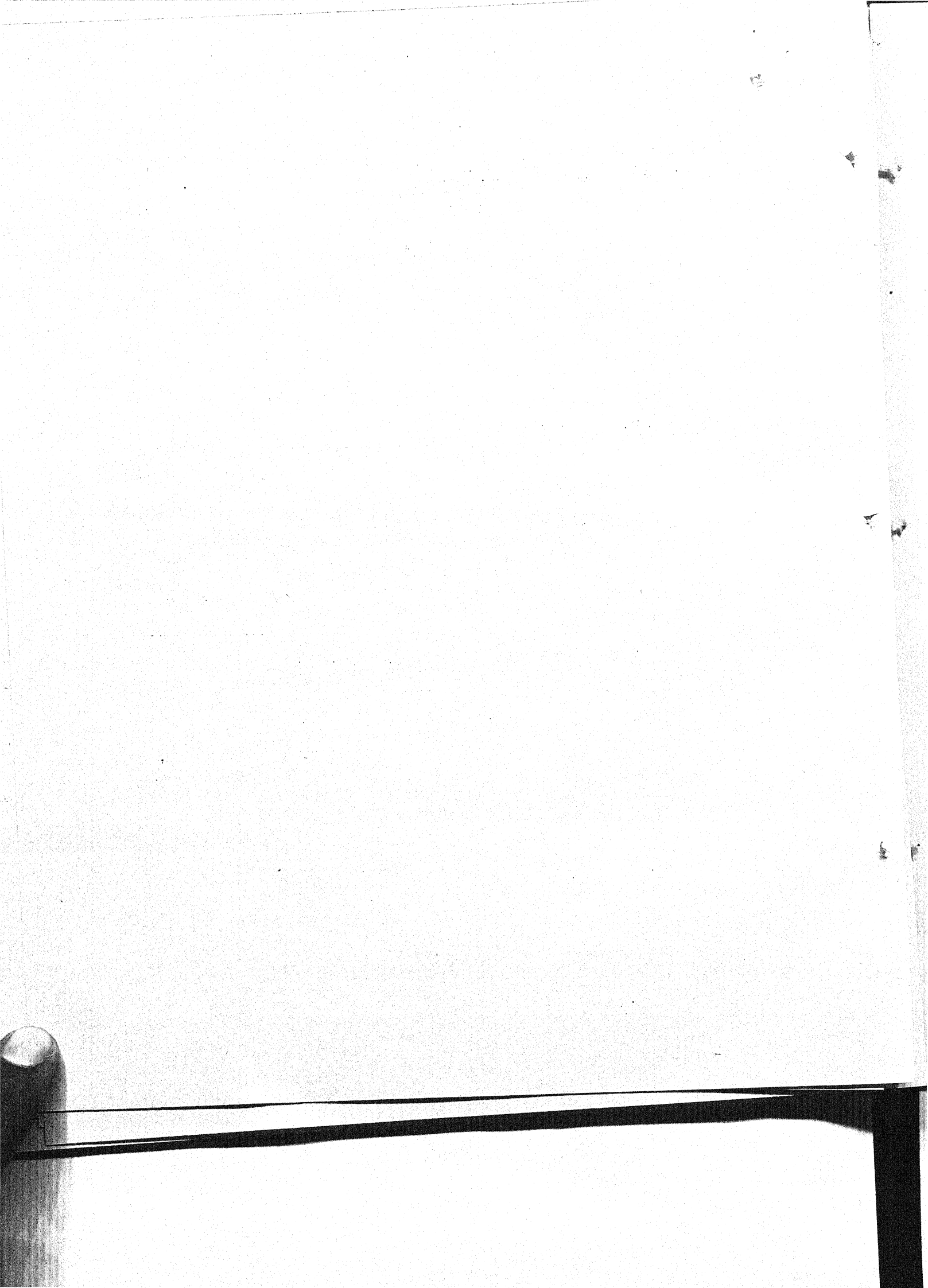
Recurring Expenditure

Staff

Designation	No.of posts	Pay scale Rs.	Amount required Rs.
1. Honorarium to Professor of Social & Preventive Medicines.	1	300/-	3,600.00
2. Honorarium to Prof. of Public Health Administration.	1	300/-	3,600.00
3. Reader	1	700-1250	8,400.00
4. Medical Officers(Lecturers) (Two male and two female)	4	400-950	19,200.00
5. Health Educator(Lecturer)	1	400-950	4,800.00

6.	Specialists' Honoraria: Dentist; Paediatrician, Ophthomologist E.N.T. Surgeon, Psychiarist.	5	300/-each	18,000.00
7.	Public Health Nurse	4	160-320	7,680-00
8.	Pharmacist	2	120-220	2,880.00
9.	Medico-Social Worker	2	160-320	3,840.00
10.	Sanitary Inspector	1	150-260	1 ,800.00
11.	Lab. Technician	1	120-220	1,440.00
12.	Inoculator	1	120-220	1,440.00
13.	Surgical room assistant	1	120-220	1,440.00
14.	Audio-Visual Operator	1	120-220	1,440.00
15.	Lab. Assistant	1	100-180	1,200.00
16.	Auxiliary Nurse Midwives	8	80-140	7,680.00
17.	Clerks	2	120-220	2,880.00
18.	Steno-typists	2	120-220	2,880.00
19.	Store-keeper	1	100-180	1,200.00
20.	Drivers	2	80-140	1,920.00
21.	Sweepers and inferior servants 5 and 10 respectively.	15	55-75	9,900.00
22.	Dai	8	55-75	5,280.00
23.	Mali(Gardener) for recreation centre	2	55-75	1,320.00
24.	Health Visitor	1	120-220	1,440.00
25.	Aya for Creche			
			Total	1,15,260.00

II. Recurring Expenditure	Rs.
(i) Pay and allowances	1,15,260-00
(ii) Drugs and medicines	40,000-00
(iii) Clothing	1,000-00
(iv) Stationery	4,000-00
(v) Telephone	1,200-00
(vi) Electricity	2,400-00
(vii) Maintenance of vehicles and running charges	4,000-00
(viii) Spectacles	1,000-00
(ix) Multipurpose Food	2,000-00
(x) Health Educational material	1,000-00
(xi) Miscellaneous Contingencies	10,000-00
TOTAL RECURRING EXPENDITURE:- Rs.	1,31,860-00
GRAND TOTAL Rs.	7,29,580-00
or Say, Rs.	7.3 lakhs.



BARODA PROPOSALS

Medical Care - Family Planning (FP) and Maternal and Child Health (MCH) Services - The city has eleven main family planning centres and 4 sub-centres. Two of these are located in the areas under reference and one belongs to the Corporation. The Family Planning Centres do not have facilities for maternity care. While family planning facilities on the whole remain under-utilised, the pressure on MCH facilities is very high. The general Hospital and the Jannabai Hospital are the only two public institutions providing maternity services to the population of the whole city. The city has 36 private maternity homes, some of them providing excellent services. But the poor sections of the population cannot avail themselves of their services. Since the public hospitals have to cater to the needs of district population also they are under severe pressure.

Adjustments though reorganisational measures can result in economies if MCH and FP activities are linked up. It is, therefore, proposed to set up three health centres offering integrated maternal and family planning services - Fatehpura Ward, industrial belt of Sayaji Gunj ward, and Pratapnagar side along the axis of Wadi Babajipura Ward. Sayajigunj ward, in fact it's a very big ward without MCH Services. In course

of time it would be necessary to provide another centre by upgrading existing family planning sub-centre into a full fledged integrated MCH and FP centre.

Health Education - There is no facility for the education of the married adults in understanding the problems of child health and child rearing. Studies under progress indicate parental education as a key factor in the optimum utilisation of health services. It is necessary to provide services of health education in the new centre. Therefore, the proposal includes services of health educators being attached to the integrated service centres.

Immunisation Services - The Corporation has a well-organised Immunisation Section under the Health Officer with a field team of about 40 persons engaged in birth registration and establishing contacts with families. Arrangements have been made to provide immunisation services to children delivered in maternity homes-public or private, as well as children born in private homes, which account for about 30 per cent of births. B.C.G. coverage for new borns is estimated to be over 80 per cent. The monthly rate of triple antigen and polio vaccination is 200 to 300 giving a coverage of about

20%. The present number of vaccinators is considered sufficient to cope with the additional numbers. The supplies of vaccine would not present any special problem. The Corporation would take care of any additional minor expenses through its normal budgetary provision although some support in matter of supplies may be needed. The Baroda Community Development service is actively carrying out the motivational work for getti children immunised. The area Immunisation Staff will be attached to the proposed integrated centre of health services.

. Nutrition Programmes - The health examination of children in serval low-income communities sponsored by the Baroda Community Development Service revealed that over 90 per cent had lop-sided physical development or suffered from mal-nutrition. About 60 per cent suffered from intestinal infestation In a sample study of slum communities jointly conducted by the Faculty of Social Work and Baroda Citizens Council, the following picture emerged regarding nutritional intake by families:-

Item	Negiligible	Percentage of families with daily intake(N-520) 100-200 grams	201-300 grams	300-400 grams	above 400 grams
Milk	--	13.0%	[illegible].5%	19.0%	38.7%
Pulses	10.6%	12.8%	27.4%	35.8%	13.4%
Vegetables	17.1%	--	32.1%	18.5%	32.3%
Non-veg.Items	72.7%	3.7%	2.1%	14.6%	6.0%

The Corporation in November,1970 started nutrition programme for children in age-group 0-3 with assistance from the Central

Government (Social Welfare Department). About 8000 children are being covered to date in the various slum areas. The feeding programme will be extended to 18000 children and will include children upto 11 years of age in the primary schools. Degree of subsidisation might vary with the income criteria to the extent it is administratively feasible. Schools where parents are in a position to pay for mid-day meals would be encouraged to do so. Educational programmes will be organised with necessary support from extension services of the department of nutrition of the M.S. University and the Baroda Citizens Council. Since the issue is already under negotiation with the State Government and there are hopeful signs of permission being received for extended coverage, the provision for nutritional feeding has not been incorporated in the financial outlay:

Day Care Services - There is no centre where working mother can expect care of their children. The percentage of working mothers in the labour force varies but in some neighbourhoods in the selected service areas it approaches 20% of the total labour force. Either they carry the infants with them causing serious inconvenience in work or leave them home to the care of older children. The older children as a result are withdrawn from the schools to look after infants (30.0% parents gave this reason for keeping children home in the survey of slum communities of Baroda.) It is therefore proposed to attach a day care centre to each of the integrated MCH and FP centres.

Health Examination,referrals and follow-up Services-

The Corporation has been contemplating a school-health check-up programme. A major effort was made during 1969 when 27252 students in the primary schools belonging to the age-group 6-14 years were examined. Out of these 10853 students did not have any health problem but 60% suffered from one defect or another distributed as follows:

Defective body structure: General Weakness	- 4164
Dental problem	- 7532
Pain in ears	- 347
Defective eye-sight	- 773
Throat infections	- 1240
Nose problem	- 169
Lungs	- 17
Deficiency of haemoglobin	- 1648
Infectious Diseases	- 64
Goitres	- 449

The Corporation has budgetted some money for health check-ups of children in Corporation managed schools this year also, but the provision for follow-up is still lacking. Unless remedial steps are taken, the advantages of nutrition programmes and other school based services cannot be fully reaped. It is therefore,proposed to set up a school health service at Corporation or Primary Education Committee level on a regular

footing to conduct comprehensive health examinations, maintain records, make referrals and follow up recommendations. The system may be extended to schools financially assisted by Corporation and other private schools on the basis of reimburseme of health examination fee charged by them from parents. The parents will need education for giving prompt attention to recommended health measures and take better care of children. Provision is also needed to disseminate the findings of various studies to the school teachers and parents.

Financial Implications - The three integrated centres for Maternal and Child Health Care and Family Planning will be created by reorganising existing services, pooling provisions and making additional provisions to fill up the gap. Each Centre may serve a population of about 30,000. The services to be provided would include:-

(1) Preventive measure - for children

(2) Check up Programme - for children and follow up

(3) Treatment programme including nutritional problems

(4) Education of the mothers

(5) Family Planning Programme

The MCH and FP centre will have the following accommodation:-

Building

(a) Doctor's examination room

(b) Waiting room for mothers and children

(c) Public Health Nurse room

(d) Compounding room

(e) Treatment room

(f) Store room

(g) Clerk room-office

(h) Nurse room

(i) Family Planning Room

(j) Baby nursery room

(k) Laboratory

(l) Labour room

(m) Operation theatre

(n) Ward room

Staff required

1. Lady Doctor-full time Grade II 425-25-525-EB-30-675-35-850
2. Paediatrician - Part-time honorarium-300/- fixed hon.
3. Public Health Nurse 1/175-8-215-EB-10-255-12-315-EB-15-345
4. Staff Nurse 3/160-6-190-EB-7-225
5. Laboratory Technician Rs.210-10-25-EB-12-310-15-340
6. Compounder 1/135-5-155-EB-7-190-EB-230-10-250
7. Clerk 1/130-5-155-EB-7-190-EB-8-230-10-240
8. Medical Social Worker 1/175-8-215-EB-10-255-12-315-EB-15-345
9. One Aya
10. One Sweeper

The total staff salary according to Govt. approved grades works out to be Rs.55,000/- per year. The family planning staff and other staff will be merged with the existing staff. The expense bill on this staff is approximately Rs.23,000/- per year. Deducting this provision, a figure of Rs.32,560 per year for additional staff has been arrived at. The cost of equipment is estimated to be Rs.50,000/- per centre. The cost of medicines, milk, vaccines, chemicals. etc., is estimated to be Rs.1 lac yearly per centre. Of these Rs.30,000/- will be available through pooling of existing provisions. An additional provision of Rs.70,000/- will be necessary for medical and other supplies for each Centre.

The provisions for Health Examination, referral and follow-up are based on the standards suggested by the Ganga Saran Committee on Child Welfare Programmes set up by Government of India. It suggested cost of Rs.30,000/- for a unit serving 5000 children. It may, however, be possible to reduce this cost through parental education programmes by persuading them to contribute to the cost of health examination or treatment and through the pooling of existing provisions. Doctors registered with the voluntary Service Bureau of the Citizens Council might also offer their honorary services.

FINANCIAL REQUIREMENTS
(Broad Classification)

ITEMS		RECURRING	NON-RECURRING
i)	Provision for building space.	-----	1,00,000
ii)	Cost of Equipment	------	50,000
iii)	Provision of Additional Staff	32,560	
iv)	Medical supplies	70,000	
v)	Nutrition Education	26,666	
		1,29,226	1,50,000

Grand total Non-recurring & recurring:- Rs.2,79,226.

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ANNEXURE NO. VI

THE INDIAN INSTITUTE OF PUBLIC ADMINISTRATION
Centre for Training & Research in
Municipal Administration
New Delhi

Project on Integrated Services to Children and Youth in Urban Areas

URBAN HEALTH CENTRE - POONA

B.J. Medical College
and
Poona Municipal Corporation

URBAN HEALTH CENTRE - POONA

B.J. Medical College
and
Poona Municipal Corporation

1. Mangalwar Peth dispensary of the Poona Municipal Corporation was upgraded and converted into U.H.C. on 14th November 1968.

2. U.H.C. is jointly maintained by the Poona Municipal Corporation and the B.J. Medical College, Poona.

3. Location - This is located in Mangalwar Peth, Poona on Barne Road and is within 15 minutes walk (about 3 km.) from B.J. Medical College, Poona.

4. Area and Population - The field practice has a population of about 25,000 of people of all Socio-economic groups. The area includes small industries and adjoins "Gadital" Slum. U.H.C. is bounded by Wellesly Road on the North, Agarwal Road on the South, Barne Road on the East and Mutha river and the connecting road from "New Bridge" on the river joining Agarwal Road near Pawale crossing the area is about 518 Hactares (two square miles).

5. Accommodation - U.H.C. is housed in the renovated old dispensary building to which another story has been added. The building now provides adequate space for services, special clinics, staff, store, sanitary facilities, seminar room, waiting room, etc...The area around the Urban Health Centre building has been well developed as garden with facilities for childrens' recreation. For safety, the area is bounded by a high wall.

6. Staff - Poona Municipal Corporation

1.	Medical Officer i/e dispensary	1
2.	Hon. Dental Surgeon	2 (one every day)
3.	Sanitary Inspector	1
4.	Compounder	1
5.	Health Visitors	2
6.	Vaccinator	1
7.	Malaria Worker	1
8.	Writer (Clerk)	1
9.	Dresser	1
10.	Cl. IV Servants	2

Staff-B.J. Medical College

Medical Officer i/e U.H.C. Reader	1
Lecturer	1
Medical Social Worker	1
Public Health Nurse	1
Registrar U.H.C.(Pediatrics)	1
Tutor(Gynaecology)	1
Technician for Lab. work	1
Clerk cum Typist	1
Senior Statistical assistants(Clerk)	2
Driver	1

7. Annual Expenditure -

(a) Poona Municipal Corporation

Pay of staff	Rs. 40,000/-
Stationary	Rs. 350/-
Uniform	Rs. 555/-
Drugs and Instruments	Rs. 3,000/-
Contingency	Rs. 1,450/-
Maintenance of Building	Rs. 500/-
Total	Rs. 44,855/-

(b) B.J. Medical College

Staff Pay	Rs. /- Shown on the establishment of the parent department and hence not included here.
Contingency	Rs. 5,000/-
Maintenance & transport	Rs. 4,000/-
Total	Rs. 9,000/-

UNICEF equipment and transport of Preventive and Social Medicine Department are used for training and service purposes; the Department of Pediatrics has also provided equipment.

8. Services provided -

(a) Training - U.H.C. is used as a field practice area for undergraduates and post-graduate students from B.J. Medical College and from Karve School of Social work shortly Interns and Public Health Nurses will also be attached to the centre for training purposes.

(b) Medical Care - Kasba Peth Municipal Dispensary started in 1920 was shifted to this place in 1955.

Daily charge / head 15 paise
Average daily attendance: 130 to 140.
Total Attendance during 1969 - 43,300
Common Diseases seen - Malnutrition, asthma, respiratory infections, tuberculosis, diarrhoeas and parasitic infestations.

(c) Antenatal Clinic - Started from 1st July 1970. A post-graduate Tutor from Department of Midwifery and Gynacology holds the clinic once a week. Over fifteen women have registered in the first month.

(d) Family Planning Centre - Contraceptives are distributed and advice is given by health visitor, services are being reorganised with the help of the tutor in Midwifery.

(e) Well-baby Clinic - This is run on every Wednesday and is supervised by the Director of Paediatrics, B.J. Medical College; about 100 babies attend at present. The director himself attends every Wednesday and holds teaching session with his Post-graduates. The other teachers engage the undergraduate at the same time; cases needing further action are followed up by the students.

(f) Milk Centre - Milk and vitamin supplements are distributed to needy children, every morning; the present average daily attendance is 60.

(g) Creche - Attendance is much dependent on other services, the nutritional supplementation being the most important. At present 18 children are on register.

(h) Immunization Clinic - Immunization against Small-pox diphtheria, Pertussis, Tetanus, Poliomyelitis, Tuberculosis and Typhoid are routinely carried out once a week at the clinic. The response of the people is increasing and is encouraging. Field immunization programme is carried out in different areas once a week in order to get acquainted with the people and to make them concious about the health facilities provided by the U.H.C.

(i) School health services: There are four Municipal Schools (Boys Nos. 12 and 15 Girls No.13 and 15) in the U.H.C/ area. Medical examination, nutritional assessment and immunization are done for students from I, II and V standards. This is provided through the final year medical students under the supervision of P.S.M. teaching staff. Follow up visits are paid by the health visitors of the second health unit (P.M.C.). Dental defects are treated at the Dental Clinic at U.H.C. Vitamins, Iron and high protein biscuits are given daily to malnourished school children. Surgical and Medical treatment is given at U.H.C. or other treatment centres of hospitals. Defective vision is attended to by supplying glasses free or on payment (depending on the income of the parents). Students of I and II standard get 200 ml. milk daily.

(j) Dental Clinic - Started mainly as a part of school health service, but now the benefit has been extended to others.

(k) Follow-up and extension service - Home visiting is regularly and systematically done by the health visitors, and as a part of training by medical students and the students from Karve Institute of social work for follow-up and Health education.

(l) Health Education - Special meetings are being arranged for school teachers and Mahila-mandal to give basic knowledge regarding health and nutrition.

(m) Research - During the short period of existence the following schemes have been undertaken:-

i. - Morbidity Survey.
ii. - Socio-economic Survey.
iii. - Evaluation of protein Biscuits as nutritional supplement to school - a pilot study.

Immediate Needs

While the facilities are being developed and strengthened some deficiencies are felt rather acutely. These are a clinical laboratory, a refrigerator for storage of sera and vaccines, additional transport and statistical records and maintenance including the family folders and Telephone connection is also badly needed.

We are very anxious to collect basic data on morbidity patterns of common infectious diseases. This information will help to plan future immunization campaigns.

Another field which U.H.C. is interested in is nutrition. An I.C.M.R. study on infant weaning foods made from locally availabl raw materials is already underway jointly by Department of Pediatrics and Department of Preventive and Social Medicine. Field implementation of the results of this study is important. For this purpose there is acute need for:

1) a good Biochemist to handle expensive UNICEF equipment.
2) a nutritionist and
3) a Medical Statistician.

These experts, it is necessary to emphasize, are only needed as instructors to train our own people.

Lastly, the health education activities cannot be further intensified for want of audio-visual aids which are needed in some quantities.